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Attitudes towards euthanasia

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There are an infinite variety of attitudes to euthanasia, each individual response to the concept being influenced by many factors. Consequently there is a literature on the subject ranging from the popular article to papers in specialized journals. This study, however, has taken a well defined sample of people, inviting them to answer a questionnaire which was designed to elicit their attitudes to euthanasia in a way which could be analysed statistically. Not surprisingly attitudes appeared to 'harden' as those answering the questionnaire grew more experienced in dealing with patients and also more professionally established. Thus it was found that of the seven groups questioned practising physicians showed more positive attitudes to euthanasia and their responses did not differ significantly from those of senior medical students. It is these groups which actually or potentially have to resolve the clinical dilemma posed by the dying patient.

This study is a report on attitudes towards euthanasia as reflected in a survey of medical, nursing and college students and practising physicians and nurses. These attitudes are of crucial significance in the decision-making process when issues of fighting for life or maintaining existence are posed.

The word 'euthanasia' arouses a mixture of feelings and images in most people. On the basis of its Greek derivation, the word comes from *eu*, meaning well, and *thanatos*, meaning death. Thus, euthanasia is defined as 'good' or easy, painless death. It is more fully defined in Webster's Dictionary (1961) as the 'act or practice of painlessly putting to death persons suffering from incurable and distressing disease'. As medical technology has advanced, the subject of euthanasia has been the topic of debate not only by physicians and other health professionals, but also by lawyers, theologians, politicians and the lay public.

The philosophical question may become a clinical dilemma for physicians and nurses or for patients and their families when the question of fighting for or maintaining life is posed and a decision cannot be avoided. This decision making may be an active or a passive process. Just as failure of those in authority to exercise control does not mean absence of control, but rather control exercised by other forces, so, making a decision not to discontinue treatment may imply making a decision to prolong marginal existence (Skinner, 1971).

Parsons and his colleagues (1973) have recently focused our attention on the importance of greater societal knowledge and participation in decision making in medical ethics. However, most of the literature stresses that the onus of making a decision ultimately falls on the physician. This is a heavy burden for the physician, but once the decision is made, the nurse, the patient and the family may live more closely with it than the doctor (Braverman, 1969; Gustafson, 1973).

Areas of conflict in attitudes to euthanasia

There are a number of areas in which attitudes toward euthanasia may give rise to conflict. One way to conceptualize such problems is to classify them as primarily interpersonal in nature in contradistinction to those that are intrapersonal. In the latter area, one starts with the premises that persons strive for cognitive balance or consistency in their attitudes and beliefs (Brown, 1965) and that the process of socialization into a professional role involves learning attitudes and beliefs as well as skills (Vollmer and Mills, 1966; *Society Today*, 1973). Hence, the intrapersonal problem is exemplified by the individual in whom there exists inconsistent attitudes relating to a particular subject, ie, the physician who believes individual freedom includes the freedom of choice to live or to die, but who also believes that every effort should be made to keep patients alive as long as possible. There is the further possibility that a professional may hold certain personal beliefs, attitudes and values that are incongruent with what he perceives as the prescriptions or proscriptions for his professional role. Thus, a physician or nurse might believe that persons should ultimately have freedom of choice regarding matters of life and death, but believe that his or her professional role requires doing everything possible to preserve or prolong life for any patient in his care. The longer the socialization process for a role the more likely that the attitudes and beliefs associated with that role will become internalized and integrated into the individual's overall belief system.

Interpersonal attitudinal problems focused on

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euthanasia exist when the attitudes and beliefs of physicians or nurses are in conflict with each other or with those of the larger society, the patient, or the family. Such interpersonal issues are confounded and made more difficult to elucidate by the very lack of congruence and consistency which may characterize the intrapersonal area. In addition, very subtle nuances of definition become magnified and of marked significance, as is true in the specialized literature on euthanasia.

A recent survey of the American public (Harris, 1974) indicated that 62 per cent of those polled believed that a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight. However, only 37 per cent believed that the patient who was terminally ill should be allowed to tell his doctor to put him out of his misery. The American Medical Association's stand reflects this wider societal perspective. The statement adopted by the House of Delegates of the American Medical Association on 4 December 1973 was:

'The intentional termination of the life of one human being by another – mercy killing – is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

'The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.'

The second part of the AMA statement above would put the onus of making the decision on the patient and his immediate family. But it is still the physician who must make the decision that biological death is imminent. The statement does not attempt to deal with situations where biological death might not be imminent, but the judgment to be made centres around the possibility of the person's life ever being 'meaningful' or 'useful'. McCormick (1974) tries to resolve this dilemma by suggesting that 'life is a value to be preserved only insofar as it contains some potentiality for human relationships'.

Rachels (1975) has argued against the AMA stand on active euthanasia or so-called 'mercy killing', pointing out that 'the process of being allowed to die' can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless. He argues that there is no moral difference between active and passive euthanasia. The differentiation hinges on making the decision that, for a given patient, death is less an evil than that patient's continued existence.

Fletcher (1968) has defined four types of euthanasia: 1) direct voluntary; 2) indirect voluntary; 3) indirect involuntary; 4) direct involuntary. 'Indirect' implies discontinuing a treatment, while 'direct' involves initiating an action. The patient participates in the direct voluntary type of euthanasia by collaborating in an act to bring about his own death, and in the indirect voluntary type by asking that life-sustaining measures be omitted or discontinued. In the two involuntary types of euthanasia a conscious decision by the patient is not involved. For example, in the case of a comatose patient decisions are usually made by the family.

Shils and Schweitzer (Kohl, 1972), proponents of the 'sanctity-of-life principle', hold that life is the most primordial experience of man and therefore that it ought always to be inviolable. They contend that man cannot either create or destroy life for life is sacred and must be so treated. To them, to take life no matter how it is done or for what reason, is to punish and any violation of the sacredness of life must inevitably lead to undesirable consequences. Data relating to both the interpersonal issues and to the problem of intrapersonal conflict are presented below.

Method: The questionnaire

An interdisciplinary research group at the University of Cincinnati Medical Center, as part of a larger study, developed a 'Questionnaire for understanding the dying patient and his family'. The construction of the questionnaire has been described elsewhere (Yeaworth, Kapp, and Winget, 1974). Embedded in the 50 items of part I of the questionnaire are five items that relate to euthanasia. These are:

ITEM 1
Regardless of his age, disabilities, and personal preference, a person should be kept alive as long as possible.

ITEM 13
Those who support the principle of 'death with dignity' endorse active as well as passive euthanasia.

ITEM 14
No matter what my personal belief, in my role as a medical or nursing professional I would fight to keep the patient alive.

ITEM 16
Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others.

ITEM 33
Some patients should be allowed to die without making heroic efforts to prolong their lives.

Each item could be responded to on a five-point scale ranging from 'strongly agree' to 'strongly

TABLE I *Characteristics of groups studied*

	Type of group						
	College students	*First-year nursing students*	*Senior nursing students*	*Registered nurses*	*First-year medical students*	*Senior medical students*	*Physicians*
No. in group	75	108	69	75	110	90	30
Setting of data collection[1]	Classroom	Classroom	Classroom	Hospital	Take home	Mailed	Mailed
Sex							
Male	17 (23)[2]	2 (2)	0	0	92 (84)	82 (91)	30 (100)
Female	52 (69)	106 (98)	69 (100)	75 (100)	11 (10)	5 (6)	0
Not answered	6 (8)	0	0	0	7 (6)	3 (3)	0
Age (yr)							
20	38 (51)	99 (92)	0	0	0	0	0
20–25	26 (35)	2 (2)	56 (81)	17 (22)	97 (88)	28 (31)	4 (13)
26–35	5 (7)	2 (2)	11 (16)	29 (39)	6 (6)	59 (66)	9 (30)
35	0	0	0	29 (39)	0	0	17 (57)
Not answered	6 (7)	5 (4)	2 (3)	0	7 (6)	3 (3)	0
Religion							
Catholic	23 (31)	38 (35)	23 (33)	22 (29)	22 (20)	24 (27)	1 (3)
Protestant	33 (44)	52 (48)	37 (54)	51 (68)	41 (37)	30 (33)	2 (7)
Jewish	4 (5)	4 (4)	2 (3)	0	15 (14)	14 (16)	24 (80)
None/other	8 (11)	0	0	0	17 (15)	10 (11)	0
Not answered	7 (9)	14 (13)	7 (10)	2 (3)	15 (14)	11 (13)	3 (10)

[1]Protocols were administered anonymously and subjects were recruited after approval by appropriate committees monitoring research on human subjects in the various colleges.
[2]Numbers in parentheses are percentages, numbers rounded to equal 100 per cent.

disagree'. Weights were assigned to statements so that responses indicative of a favourable attitude toward euthanasia were assigned a low score, ie, a weighting of 1 or 2, while attitudes favourable to the 'sanctity-of-life principle' were assigned a score of 4 or 5. Responses indicative of indecision or uncertainty were weighted 3.

The responses to the five euthanasia items were abstracted from the completed questionnaires of a variety of subjects: college students, first-year and senior nursing students, first-year and senior medical students, practising registered nurses and practising physicians. Table I provides information on the composition of these samples.

Results

Table II indicates the percentage responses to the five euthanasia items for each of the seven groups. Most individuals in all the groups disagree with statement no. 1. This disagreement with keeping a patient alive regardless of age, disability and personal preference is most marked in the senior medical student group, and is least marked in the first-year nursing students and the college students. Both nursing students and medical students show a decided difference in the proportion of those who are undecided when first-year men are compared to seniors.

Item no. 13 asks for attitudes regarding the issue of equating active with passive euthanasia within the overall rubric of 'death with dignity'. This item contains ambiguous cognitive and attitudinal components which apparently evoke ambivalence and uncertainty. The variance in weighted responses is great and the proportion of those answering 'undecided' in each group is very high compared to responses to the other four items about euthanasia. Physicians and nurses in practice show proportionately the fewest 'undecided' and 'agree' responses and thus, the highest percentage of responses presumably distinguishing active from passive euthanasia.

Responses to the statement about fighting to keep a patient alive (item no. 14) again reveal marked differences among the seven sampled groups. Practising physicians, nurses and senior medical students are the three groups that indicate the most disagreement with the notion of fighting to keep a patient alive at any cost. Indecision in this area is greater for senior than for first-year nursing students but is considerably less for senior than for first-year medical students.

Issues of autonomy for the terminally ill patient are raised in item no. 16. While the majority of all

TABLE II *Percentage response to five euthanasia items by seven groups of respondents*

No.	Group	*Strongly agree* (%)	*Agree* (%)	*Undecided* (%)	*Disagree* (%)	*Strongly disagree* (%)
Item 1	*Regardless of his age, disabilities, and personal preference, a person should be kept alive as long as possible.*					
75	College students	8	19	19	37	17
108	First-year nursing students	4	13	30	41	12
69	Senior nursing students	3	11	13	28	45
75	Registered nurses	4	11	23	34	28
110	First-year medical students	2	6	21	36	35
90	Senior medical students	0	0	9	38	53
30	Physicians	10	7	10	33	40
Item 13	*Those who support the principle of 'death with dignity' endorse active as well as passive euthanasia.*					
75	College students	0	21	59	17	3
108	First-year nursing students	1	19	46	25	6
69	Senior nursing students	0	14	54	22	10
75	Registered nurses	0	19	32	33	16
110	First-year medical students	4	21	45	23	8
90	Senior medical students	0	9	35	40	16
30	Physicians	3	10	13	50	23
Item 14	*No matter what my personal beliefs, in my role as a medical professional I would fight to keep the patient alive.*[1]					
75	College students	25	35	24	12	4
108	First-year nursing students	24	45	22	6	1
69	Senior nursing students	13	28	32	19	9
75	Registered nurses	11	36	24	25	4
110	First-year medical students	7	25	41	23	5
90	Senior medical students	0	24	23	43	10
30	Physicians	13	20	17	40	10
Item 16	*Individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others.*					
75	College students	17	48	19	15	1
108	First-year nursing students	18	45	18	14	4
69	Senior nursing students	17	42	25	16	0
75	Registered nurses	13	46	21	15	5
110	First-year medical students	19	47	24	7	4
90	Senior medical students	23	51	16	9	1
30	Physicians	3	67	10	20	0
Item 33	*Some patients should be allowed to die without making heroic efforts to prolong their lives.*					
75	College students	20	41	16	13	9
108	First-year nursing students	19	47	19	11	5
69	Senior nursing students	29	59	7	1	3
75	Registered nurses	50	44	5	1	0
110	First-year medical students	27	50	19	3	1
90	Senior medical students	62	34	3	1	0
30	Physicians	40	53	0	7	0

[1]Non-medical personnel answering this question were asked to respond as they thought they might *if* they were a doctor or a nurse.

seven of our subject groups agree on the abstract notion of freedom of choice, the two groups of practising professionals show greater disagreement proportionately than any of the student groups. First-year medical and senior nursing groups are, again, the two with the highest proportion of 'undecided' responses.

There is overwhelming agreement with item no. 33 that 'some patients should be allowed to die without making heroic efforts to prolong their lives'. For both the nursing and medical students there are markedly fewer 'undecided' responses in senior students as compared with those of first-year students.

For each subject within the seven groups, a score was derived for the five euthanasia items by

TABLE III *Means and standard deviations on euthanasia and other attitudes towards death and dying*

Group	No.	*Five euthanasia items*		*Other attitudes towards death & dying*		*Pearson r*	P
		Mean	*S D*	*Mean*	*S D*		
College students	75	14.27	3.56	65.36	8.03	0.248	<0.05
First-year nursing students	108	14.09	2.92	64.67	7.63	0.126	ns
Senior nursing students	69	12.32	2.81	55.49	6.83	0.038	ns
Registered nurses	75	12.17	2.49	66.65	17.70	0.134	ns
First-year medical students	110	12.29	2.81	63.94	7.62	0.338	<0.01
Senior medical students	90	10.01	2.15	61.72	8.36	0.382	<0.01
Physicians	30	11.40	3.76	67.10	8.04	0.743	<0.001

summing the weights. A low score (14 or less) indicated a tendency towards a favourable attitude towards 'death with dignity'. A high score (15 or more) was indicative of a positive attitude towards the 'sanctity-of-life principle'. Table III shows the average scores for the seven groups for the euthanasia subscale as well as the average for other attitudes toward deaths and dying. The correlation (Pearson r) of these two scores is also shown. The least accepting attitudes on issues of euthanasia are held by college students, although first-year nursing students are quite similar. The most accepting attitudes are held by senior medical students and by practising nurses and physicians.

Using Duncan's multiple range test and a confidence level of 0.01 (Edwards, 1964), each mean was

TABLE IV *Differences between the means on euthanasia items for seven groups of subjects*[1]

Group	$\bar{X}$	*A* (1) *Senior medical students* 10.01	*B* (2) *Physicians* 11.40	*C* (3) *Registered nurses* 12.17	*D* (4) *First-year medical students* 12.29	*E* (5) *Senior nursing students* 12.32	*F* (6) *First-year nursing students* 14.09	*G* (7) *College students* 14.27	*Shortest significant ranges*
Senior medical students[A]	10.01		1.39	2.16	2.28	2.31	4.08	4.26	$R_2=1.33$
Physicians[B]	11.40			0.77	0.89	0.92	2.69	2.87	$R_3=1.39$
Registered nurses[C]	12.17				0.12	0.15	1.92	2.10	$R_4=1.42$
First-year medical students[D]	12.29					0.03	1.80	1.98	$R_5=1.45$
Senior nursing students[E]	12.32						1.77	1.95	$R_6=1.47$
First-year nursing students[F]	14.09							0.18	$R_7=1.49$
College students[G]	14.27								

[1]Any two means *not* underscored by the same line are significantly different at <0.01, while any two means underscored by the same line do not differ significantly.

tested against every other mean. Table IV displays the differences between the means for our seven groups and allows ready comparison. Thus, senior medical students do not differ significantly from physicians on euthanasia as measured by our five items, but are significantly lower than the five other groups. Physicians, registered nurses, first-year medical students, and senior nursing students are significantly lower than first-year nursing students and college students, while the latter do not differ significantly from each other.

If one looks at general issues of relating to the dying patient and his family, as indicated in the responses to the total questionnaire, the most understanding and emphatic responses, on the average, are those of senior nursing students. Table III shows that nurses and physicians who have been working at their professions yield the highest mean scores. This difference in the rating of the euthanasia subscale and the 28 weighted items of the other areas of care of the dying patient is revealed in the wide fluctuations in the correlation coefficients for the seven groups. For the three nursing groups, attitudes towards euthanasia appear to have no relationship to other attitudes towards the dying person and his family. For college students, the two measures of attitudes are somewhat correlated ($P<0.05$) while for medical students both near the beginning and near the completion of the medical school experience there is a high correlation ($P<0.01$). For the sample of 30 practising physicians the correlation is extremely high ($P<0.001$).

Not only are there significant differences among these seven groups of subjects on attitudes towards euthanasia and other issues relating to the dying patient, there are also marked differences in the apparent inconsistent responses as indicated by within-person variation. A person was identified as having 'discrepant' responses if his five weighted responses contained weightings indicative of both positive and negative attitudes toward euthanasia. Thus, persons whose weightings on the five items were 1–2–1–2–3 or 4–5–3–4–5 were not labelled discrepant, but persons with scores of 1–5–3–2–4 or 2–2–2–3–5 were so identified. Table V shows the number and percentage of individuals with 'discrepant' responses for each group. Student nurses, whether first-year or senior, and practising nurses, were all higher in percentage of discrepant responses than beginning or senior medical students or practising physicians. First-year nursing students with 73 per cent discrepant responses showed the greatest inconsistency within the five euthanasia items.

TABLE V *Number and percentage of discrepant responses by groups*

Group	*No.*	*No. of individuals with discrepant response*
College students	75	46 (61.3%)
First-year nursing students	108	79 (73.1%)
Senior nursing students	69	41 (59.4%)
Registered nurses	75	52 (69.3%)
First-year medical students	110	54 (49.1%)
Senior medical students	90	33 (36.7%)
Physicians	30	12 (40.0%)

Discussion

If one considers the five statements on euthanasia, three of them (nos. 1, 14 and 33) deal directly with attitudes toward dying patients. Of these three, the statement which evokes the most agreement with the concept of euthanasia is no. 33, 'some patients should be allowed to die without making heroic efforts to prolong their lives'. Ninety-six per cent of the senior medical students and 93 per cent of the practising physicians agree. The practising registered nurses and the senior nursing students indicate, respectively, 94 per cent and 88 per cent agreement. It appears that only the naïve, college students and first-year nursing and medical students, have much ambivalence or disagreement. One wonders what cultural factors have created the expectation in these three groups of young subjects that heroic efforts should be made to prolong the lives of everyone, no matter what the circumstances.

Statement no. 1 introduces individual variables to influence the decision: 'regardless of his age, disabilities and personal preference, a person should be kept alive as long as possible'. This evokes an increase in indecisiveness in comparison to statement no. 33 and a decrease in the amount of agreement with the idea of euthanasia. Statement no. 14 evokes role expectations: 'no matter what my personal beliefs, in my role as a medical professional, I would fight to keep the patient alive'. Once such expectations are considered, the agreement with the idea of euthanasia decreases for all groups. Aside from the practising registered nurses there is a marked increase in indecisiveness. Generalizing the reactions to these three statements, indecision increases as modifying variables are introduced. A complex choice lends itself less well to a strong position.

Statement no. 13, 'those who support the principle of "death with dignity" endorse active as well as passive euthanasia', introduces a primary cognitive component. All student groups showed much more indecision in their responses to this statement. This finding suggests lack of knowledge of the 'death with dignity' concept, and a poor understanding of the meanings of 'active' and 'passive' euthanasia.

Statement no. 16, 'individual freedom of choice ultimately should mean freedom of choice to live or die within a context of responsibility for self and others', moves away from professional role expectations and specific variables. It taps a broad philosophical approach to individual rights and responsibilities. Registered nurses and senior student nurses both have 59 per cent agreement with this statement, less than the other five groups.

If one discounts the responses to statement no. 13, which depend more on cognitive than affective components of attitudes to euthanasia, there is a consistency among first-year medical students, senior medical students and practising physicians. The senior medical students have the most positive attitudes toward euthanasia, followed by practising physicians and first-year medical students. There is less consistency among practising nurses and nursing students. The data also indicate that nurses' attitudes toward euthanasia are not correlated with their overall attitudes toward death and dying. A greater proportion of nurses, whether students or practising professionals, have discrepant responses to statements about euthanasia.

These findings pique our curiosity and stimulate speculation on a *post hoc* basis. Such a state of indecision could be favourably viewed as an openness to shift to one position or another on the basis of additional information. Attitudinal research indicates that a strongly held attitude is usually resistant to change. Krech *et al* (1962) indicate that the ability to alter our concepts and beliefs is determined by our ability to deal with ambiguities and inconsistencies. Studies of the nursing role have shown that it is especially fraught with inconsistencies and conflicting expectations not only because of the nature of the job itself but also because 95 per cent of nurses are female and women's role in our society is changing and has poorly defined expectations. This suggests that women, especially nurses, have learned to tolerate more indecision and inconsistencies in their attitudes than men, who are more likely to have a clearer professional identity. An alternative explanation could be that women have not thought through their attitudes to the point of an integrated perspective. This would leave them more vulnerable to emotional indecision. As more men enter the nursing profession and more women become physicians it will be easier to delineate the extent to which professional identity rather than gender is the crucial factor.

Another possible explanation of the differences between the disciplines in consistency of personal attitudes may be attributed to differences in socialization to roles (Kramer, 1968). Sociological theory indicates that the longer the socialization process, the more likely the attitudes, values and beliefs associated with a role will be internalized. Medical students have a longer period of professional training and so are more likely to internalize the attitudes, values and beliefs that are associated with the physician's role. If this assumption is valid, practising physicians and physician teachers therefore have a more consistent set of attitudes, values and beliefs to convey to students. Nurses not only have shorter periods of professional training, but with the multiplicity of programmes, there are marked differences in the length of nursing education. Because of this variation, nurses are less likely than physicians to have a consistent set of attitudes, values and beliefs to transmit to nursing students.

Conclusion

In a survey of medical, nursing and college students and practising physicians and nurses there were significant attitudinal differences in responses to statements about euthanasia. Senior medical students and practising physicians did not differ significantly from each other but were more positively orientated towards euthanasia than registered nurses, first-year medical students, senior and first-year nursing students, and other college students. Attitudes toward euthanasia were positively correlated with other attitudes towards the dying patient and his family for all groups but the two groups of nursing students and the practising nurses. These three nursing groups and the college students also showed proportionately the greatest within-person inconsistency in responses to the euthanasia items.

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